

Dietary Prescription Request for **Student without Disability**
Child Nutrition Programs

PARENT/GUARDIAN MUST COMPLETE THIS SECTION

Student Name: _____

Date of Birth: _____ Age: _____

School Attended: _____

Grade: _____

Parent/Guardian Name: _____

Phone Number: _____

Mailing Address: _____

City/State/Zip: _____

Signature of Parent/Guardian

Date

DIET ORDER - RECOGNIZED MEDICAL AUTHORITY MUST COMPLETE THIS SECTION.

The definition of a Recognized Medical Authority in Washington State is limited to the following professionals only: Medical Doctor; Doctor of Osteopathy; licensed Physician's Assistant with prescriptive authority; licensed Advanced Registered Nurse Practitioner with prescriptive authority; or licensed Naturopathic Physician.

What is the student's special dietary need?

List all food(s) to be omitted:

List all food(s) to be substituted:

List any foods that require texture modification and describe how to prepare (chop, grind fine, puree, etc.):

Describe any other comments about the student's eating or feeding patterns.

Signature of Recognized Medical Authority

Date